

Organization Update Form

Joint Commission on Accreditation of Healthcare Organizations

Please complete this form to update the Joint Commission on changes in your organization. We must receive this form *within 30 days* of the change. Please type your responses directly on this form, print and send to the address below. If the change is related to a Joint Commission accredited laboratory, please complete the "[Laboratory Organization Update Form](#)".

Complete only the sections that apply to the changes you are reporting. Enter your name, sign the form, and mail it to the address listed below.

Current Organization Information

Always complete this section.

Organization Name: _____
HCO ID: _____
Street: _____
City, State, Zip _____
Phone Number: _____
Fax Number: _____
Preparer's Name: _____
Preparer's Signature: _____
Title: _____
Date: _____

Current Owner Information

Name: _____
Street: _____
City, State, Zip _____
Phone Number: _____
Fax Number: _____

Current CEO (or equivalent)

Name: _____
Title: _____
E-mail Address: _____
Phone Number: _____
Fax Number: _____

Current President of Medical/Professional Staff (or equivalent)

Name: _____
Title: _____
E-MAIL Address: _____
Phone Number: _____
Fax Number: _____

Current President of Governing Body (or equivalent)

Name: _____
Title: _____
E-MAIL Address: _____
Phone Number: _____
Fax Number: _____

Current Primary Contact Person (Individual responsible for completing the Joint Commission survey application)

Name: _____
Title: _____
E-mail Address: _____
Phone Number: _____
Fax Number: _____

Updated Organization Information

Organization Name: _____
Street: _____
City, State, Zip _____
Phone Number: _____
Fax Number: _____

New Owner Information

Name: _____
Street: _____
City, State, Zip _____
Phone Number: _____
Fax Number: _____

New CEO (or equivalent)

Name: _____
Title: _____
E-mail Address: _____
Phone Number: _____
Fax Number: _____

New President of Medical/Professional Staff (or equivalent)

Name: _____
Title: _____
E-MAIL Address: _____
Phone Number: _____
Fax Number: _____

New President of Governing Body (or equivalent)

Name: _____
Title: _____
E-MAIL Address: _____
Phone Number: _____
Fax Number: _____

New Primary Contact Person (Individual responsible for completing the Joint Commission survey application)

Name: _____
Title: _____
E-mail Address: _____
Phone Number: _____
Fax Number: _____

Please use company letterhead to provide details of the following changes:

Site change

Has your organization added or deleted any sites, or have any of your sites moved? Please list the name of each affected site, its address and telephone number, the services provided at the site, and the effective date of the change.

Services change

Has your organization added or deleted services since your last accreditation survey? Please tell us about the service changes and effective dates of the changes. Examples include:

- your nursing home adds a dementia unit.
- your home medical equipment organization, which formerly provided only basic equipment, adds oxygen-related equipment to its service line.

Merger

Has your organization merged two or more organizations? Please submit the following:

- names of the organizations merged
- Joint Commission identification numbers of the organizations merged
- effective date of the merger and any other detailed information regarding the merger

Acquisition

Has your organization acquired one or more organizations? Please include the following in your letter:

- names of the organizations acquired
- Joint Commission identification numbers of the acquiring organization and the organizations acquired
- effective date of the acquisition and any other detailed information regarding the acquisition

Organization closure

Are you closing your entire organization, or closing an accredited program in your organization? Please tell us the name and address of the organization and the effective date of closure.

Please mail your updates *within 30 days* of the change to:

Joint Commission on Accreditation of Healthcare Organizations
ATTN: Accreditation Operations/Service Team East, Central or West (pick one region from list below)
One Renaissance Blvd.
Oakbrook Terrace, IL 60181

For office use only:

Date Updated: _____
Initials: _____
Acknowledged Date: _____
Initials: _____

Service Team East Region: CT, DC, DE, GA, FL, MA, MD, ME, NC, NH, NJ, NY, PA, RI, SC, VA, VT, Canada, U.S. territories

Service Team Central Region: AL, AR, IA, IL, IN, KY, LA, MI, MO, MS, OH, TN, WI, WV

Service Team West Region: AK, AZ, CA, CO, HI, ID, KS, MN, MT, ND, NE, NM, NV, OK, OR, PR, SD, TX, UT, WA, WY